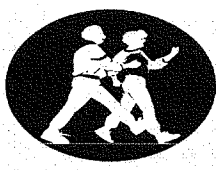

Living a Healthy Life
With Chronic Conditions

Host Organization Data

Host Organization: _____

Address: _____

City: _____ **Zip Code:** _____

Host Organization Type: (circle one)

1---Area Agency on Aging

2---State Public Health Department

3---County Health Department

4---Health Care Organization (e.g., hospital, clinic, etc.)

5---Faith-based Organization (e.g., church)

6---Recreational Organization or Facility (e.g., YMCA)

7---Municipal Government

8---Senior Center

9---Workplace

10--Multi-purpose Social Services Organization

14—Other (Please enter description of the organization)

_____

_____

Supporting Host Organizations:

_____

_____

Living a Healthy Life
With Chronic Conditions

Living A Healthy Life With Chronic Conditions

Implementation Site Data

Implementation Site Name: _____

Address: _____

City: _____ **Zip Code:** _____

Implementation Site Type: (Circle One)

4---Health Care Organization (hospital, clinic etc.)

5---Faith-based Organization (church etc.)

8---Senior Center

9---Workplace

10--Multi-purpose Social Services Organization

11--Other Community Center

12--Parks Department Facility

13--Residential Facility

14--Other (Please enter description of the site)

_____

_____

Host Organization Name (name of sponsoring organization(s) :

_____

_____

Living a Healthy Life
With Chronic Conditions

Living A Healthy Life With Chronic Conditions

Participant Survey

Thank you for taking a few minutes to answer some brief questions about how your chronic health condition affects your life. Please try to answer each question. There are no right or wrong answers, and your responses will not affect any services or programs you are receiving. If you have any questions about what is being asked, please ask your class leader. In addition, we may be contacting you again in about 6 months to learn more about how the Living a Healthy Life class may have impacted your life and health. All of your information on these surveys will be kept confidential.

Thank you for taking the time to complete this questionnaire!

For questions or comments, please contact Constance McCloy, PT, EdD at the Center for Aging & Community, University of Indianapolis: (317) 791- 5926 cmccloy@uindy.edu

In coordination with the Centers for Disease Control and Prevention

Healthy Aging Research Network

Funding provided by the Center for Healthy Aging at the National Council on Aging

Living a Healthy Life
With Chronic Conditions

Participant Survey

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Date of Birth: _____/_____/_____ **Phone Number:** _____

Month Day Year

Address:_____ **City:** _____

Home Zip Code _ _ _ _ _

Gender:

- ☐ Female
- ☐ Male

Highest Level of Education Completed (check one)

- ☐ Less than High School
- ☐ Some High School
- ☐ High School Graduate
- ☐ Some college or vocational school
- ☐ College Graduate
- ☐ Graduate School

Current Marital Status (check one)

- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ Separated
- ☐ Never Married
- ☐ Partnered

Living Arrangements Today (check one)

- ☐ I Live Alone
- ☐ I Live With Someone

Would you say that in general your health is (circle one):

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Do you speak a language other than English at Home? ☐ Yes ☐ No

If yes, what language(s)_____

Please select one or more of the following that best describe your race or ethnicity (check ALL that apply):

☐ American Indian or Alaskan Native
☐ Asian or Asian-American
☐ Black or African-American
☐ Hawaiian Native or Pacific Islander
☐ Hispanic/ Latino
☐ White/ Caucasian
☐ Other

Please select the chronic health conditions you have (check ALL that apply):

☐ Diabetes
☐ Heart Disease
☐ Hypertension (high blood pressure)
☐ Lung Disease (asthma, emphysema, bronchitis)
☐ Arthritis/ Rheumatic Disease
☐ Cancer
☐ Osteoporosis
☐ Other (please write condition:_____)

Now thinking about your PHYSICAL HEALTH, for how many days during the past <u>MONTH</u> was your physical health NOT good (e.g., illness or injury)?

_____ **Days**

Please answer the following questions as they apply to you: (circle response)

Do you have pains, tightness or pressure In your chest during physical activity (walking, climbing stairs, household chores, etc.)?	**Yes**	**No**
Do you currently experience dizziness or lightheadedness?	**Yes**	**No**
Have you ever been told you have high blood pressure?	**Yes**	**No**
Do you have pain, stiffness or swelling that limits or prevents you from doing what you want or need to do?	**Yes**	**No**
Have you fallen in the past year, or do you feel unsteady or use a cane or walker while standing or walking?	**Yes**	**No**
Is there a health reason not mentioned why you should be concerned about starting an exercise program?	**Yes**	**No**

We are interested in learning whether or not you are affected by fatigue. Please circle the number below that describes your fatigue level in the past 2 weeks:

1 2 3 4 5 6 7 8 9 10

No Fatigue Severe Fatigue

During the past MONTH, other than your regular job, did you participate in any physical activity or exercise (e.g., walking, biking, gardening, golf etc.)?

- ☐ **Yes**
- ☐ **No**

How many days in the past WEEK were you physically active for at least 30 minutes per day? (it does not have to be done all at one time). Examples are: walking, biking, gardening, heavy housekeeping, swimming etc.

_____ **Days in Past Week**

How did you hear about this program?

Thank you for completing this survey!

CAC UNIVERSITY of INDIANAPOLIS.
CENTER FOR AGING & COMMUNITY

Indiana State Department of Health

For Staff Only

Site ID: _____ *Participant ID:* _____